FINAL REPORT
OF THE
SELECT JOINT COMMISSION
ON
MEDICAID OVERSIGHT

Indiana Legislative Services Agency
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November 2007

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2007

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Select Joint Commission on Medicaid Oversight

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November 1, 2007

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FINAL REPORT

Select Joint Commission on Medicaid Oversight

I. STATUTORY AND LEGISLATIVE COUNCIL DIRECTIVES

The Indiana General Assembly enacted legislation (IC 2-5-26) directing the Commission to do the following:

> (1) Determine whether the contractor for the Office of Medicaid Policy and Planning (OMPP) under IC 12-15-30 that has responsibility for processing provider claims for payment under the Medicaid program has properly performed the terms of the contractor's contract with the state.
> (2) Study and propose legislative and administrative procedures that could help reduce the amount of time needed to process Medicaid claims and eliminate reimbursement backlogs, delays, and errors.
> (3) Oversee the implementation of a case-mix reimbursement system developed by OMPP and designed for Indiana Medicaid-certified nursing facilities.
> (4) Study and investigate any other matter related to Medicaid.
> (5) Study and investigate all matters related to the implementation of the Children's Health Insurance Program established by IC 12-17.6.

The Legislative Council also assigned the additional responsibility of studying issues relating to the state's practice of buying out Medicaid-certified beds in health facilities (based on HB 1679-2007).

II. INTRODUCTION AND REASONS FOR STUDY

The Indiana Medicaid program represents approximately $5.7 billion dollars, or about 23% of the $24.7 billion FY 2008 state budget (all funds). Of this amount, the program is appropriated $1.587 billion, or about 12.2% of the total appropriations from the General Fund and Property Tax Replacement Fund. The program has an average monthly enrollment projection of approximately 882,000 Indiana citizens. Due to the importance of this program in the state budget and to the program's recipients and providers, the Select Joint Commission on Medicaid Oversight was established as a permanent commission to provide legislative branch oversight of this state function.

In addition, current Indiana law under P.L. 3-2007, SECTION 1, that establishes the Quality Assessment Fee (QAF) for nursing facilities states that the Select Joint Commission on Medicaid Oversight is to review the implementation of the QAF and that OMPP may not make any change to the reimbursement for nursing facilities unless the Select Joint Commission on Medicaid Oversight recommends the reimbursement change.

III. SUMMARY OF WORK PROGRAM

The Commission met five times during the 2007 interim: July 30, August 15, September 10, October 4, and October 29. All meetings were held at the State House.

Meeting #1 - July 30, 2007

The Commission received an update from the Family and Social Services Administration (FSSA) regarding EDS, the state's Medicaid claims payment contractor. Dr. Jeff Wells, Director of OMPP, updated the Commission on the implementation of the Indiana Care Select Program, a care management program serving the population currently under Medicaid Select and for many of those in the traditional Medicaid fee-for-service program. FSSA also provided an update on nursing facility reimbursement rate changes. Public testimony was also received on the topic of nursing facility reimbursement. Testimony was also received on the impact of a new federal rule which will impact payments made to county and municipal hospitals and to community mental health centers.

Meeting #2 - August 15, 2007

The Commission received an update from OMPP and EDS on claims payment statistics for the three Medicaid managed care organizations (MCOs), as well as an update on reimbursement in the Indiana Health Care Program (IHCP), which includes more of the state's health care programs than only Medicaid. FSSA provided a brief history and overview of the Closure and Conversion Fund and the development of the new reimbursement rule, and public testimony was received on this issue. The Commission formally recommended the adoption of the proposed rule changes. Mr. Keenan Buoy of Myers and Stauffer, the state's nursing facility rate-setting contractor, provided a report on the Quality Assessment Fee. There was brief discussion on the buy-out of Medicaid-certified nursing facility beds. FSSA also provided an update on the federal reauthorization of the state Children's Health Insurance program (CHIP).

Meeting #3 - September 10, 2007

The Commission received an update from OMPP regarding access to MCO providers and an update from FSSA on the progress of the federal reauthorization of the CHIP program. The Commission also heard a presentation by the Division of Aging on the nursing facility closure and conversion issue and the implementation status of SEA 493-2003. The Commission also received public testimony on the nursing facility Quality Assessment Fee. The Commission also received public testimony on publicly funded home and community-based care services in Indiana. The Commission also heard public testimony detailing concerns with the contracting process used by OMPP in securing incontinence, urological, and ostomy supplies.

Meeting #4 - October 4, 2007

Dr. Jeff Wells updated the Commission on OMPP's plans for increasing physician reimbursement in the Medicaid program, as well as well as the managed care behavioral health contracts in the Medicaid risk-based managed care program.

Meeting #5 - October 29, 2007

The Commission heard testimony on the procurement process undertaken by OMPP for incontinence supplies and from individuals concerned about the process and the procedures that may result. The Commission received an update on claims payment and provider access. The Commission also heard testimony on ambulatory services reimbursement in the Medicaid program and received updates on HEDIS reporting, Indiana's compliance with the federal Deficit Reduction Act of 2005, state sources of Medicaid funding, and the coordination of benefits study required by SEA 566-2007. The Commission also considered legislative bill drafts and approved the Commission's final report.

IV. SUMMARY OF TESTIMONY

The Commission heard testimony on several issues over the course of the interim.

Nursing Facility Reimbursement Issues / Closure and Conversion Fund

Mr. Mitch Roob, Secretary of the Family and Social Services Administration, provided a brief history of the Closure and Conversion Fund. Mr. Sid Norton, Chief Financial Officer of FSSA, reported the balance in the Closure and Conversion Fund at $32.6 M and explained that the Centers for Medicare and Medicaid Services (CMS) have not yet approved any plan put forward by OMPP that would allow the leveraging of these funds with federal matching funds. He also reported that the funds were segregated in an account outside the use of FSSA and are controlled by the State Budget Agency.

Sec. Roob, describing why the state might want to control the supply of nursing home beds, stated that nursing facilities market directly to hospitals to get hospital discharges if beds are available, and that most states regulate supply through a certificate-of-need program or moratorium.

Mr. Steve Smith, Director of the Division of Aging, described the nursing facility closure and conversion issue beginning with the passage of SEA 493-2003 and the establishment of the nursing home Quality Assessment Fee. His presentation included a detailed listing of the objectives and outcomes of SEA 493; a summary of Division of Aging expenditures for FY 2006 and FY 2007; a description of the objective of shifting the relative expenditures between institution-based health care delivery, support services, community services, and individual services; a comparison of the number of individuals receiving non-Medicaid services; a comparison of state strategies for

controlling the supply of state-funded nursing facility beds, including certificate-of-need programs and moratoriums; and the outcomes and results of SEA 493, thus far, including outcomes such as declines in nursing home utilization, reductions in the Aged and Disabled Waiver wait list and the CHOICE wait list, etc.

Mr. Smith also provided data on state-by-state expenditures for institutional services and community-based services and the implementation status of SEA 493.

Mr. Smith stated that there are approximately 522 nursing facilities in Indiana, of which 475 are Medicaid-certified. The 475 facilities have an average occupancy rate of about 85%, and there is a wide variation in quality of the facilities. Mr. Smith added that the state would like to have some flexibility in closing facilities.

Mr. Smith added that the QAF was intended to be split between the state General Fund, with the remainder designated to enhance Medicaid reimbursement for nursing facilities. Since the expiration of the rule implementing the Closure and Conversion Fund and because of the new reimbursement rule for nursing facilities, funds are no longer available for closure and conversion purposes.

Regarding the issue as to whether statutory definitions of closure and conversion would help, Sec. Roob offered the following definitions:

> Closure - When a Medicaid-participating nursing facility completely ceases operation as a nursing facility.
>
> Conversion - When a Medicaid-participating nursing facility changes from providing institutional care to providing alternative, non-institutional care.

The Commission took no action on the definitions.

Mr. Bob Decker, representing Hoosier Owners and Providers for the Elderly, testified that the nursing home industry feels that money in the Closure and Conversion Fund is part of the 80% of the QAF, which is designated by statute for payments to nursing facilities, and that these funds should be available for payments to nursing facilities if the use for closure and conversion is not approved by CMS. Mr. Decker testified that the integrity of the case-mix reimbursement system for nursing facilities can be maintained without any additional cost to the state General Fund by using the funds set aside for, but not used for, closure and conversion.

Mr. Jim Leich, representing Indiana Association of Homes and Services for the Aging, reviewed the origin of the Closure and Conversion Fund and explained that no expenditures have been made from the fund for closure or conversion purposes since CMS has not approved a mechanism for payments which can be used to leverage federal funding.

Sec. Roob stated that if the General Assembly were to consider expanding the Quality Assessment Fee, he strongly recommends the legislation be written to allow FSSA to

do this at their discretion because of complications created by negotiations with the federal agencies.

Mr. Keenan Buoy, Myers and Stauffer, Medicaid rate contractors for the state, provided a report comparing the estimated reimbursement that would have occurred had there been no Quality Assessment Fee with the net reimbursement with the QAF. Each nursing facility in the state receiving Medicaid reimbursement and the amount each facility is estimated to gain or lose under the assessment, net of the annual assessment amount, was listed in the report. He added that facilities exempt from assessment include hospital-based facilities and continuing care retirement centers. Mr. Buoy added that $1.4 million is collected from non-Medicaid facilities, and that four non-Medicaid facilities currently owe the state $2.6 million.

Mr. Mark Scherer, Indiana Health Care Association (IHCA), provided the Commission additional information on the QAF. Mr. Scherer stated that when the QAF was enacted in 2003, a portion of the fee was to go into nursing facility reimbursement rates predicated on quality improvement. Suggestions or possibilities for distributing the remainder of the fee amount included the following:

- Converting report card scores to a dollar value
- Providing an add-on payment for Alzheimer's units
- Providing incentives to providers to help them get out of business
- Creating behavioral centers for violent residents
- Providing for sprinklers and smoke detectors
- Conducting user-satisfaction surveys

Regarding the proposed reimbursement rule change for which the Commission is to review, Mr. Norton reported that nursing facility rates are likely to increase by 9% in the absence of the proposed rule. He explained the steps the administration took to constrain expenditures in FY 2007 and the necessity of limiting nursing facility expenditures within the Medicaid budget to a growth rate of not more than 5%.

Sec. Roob described the development of the reimbursement rule that the Commission was reviewing. He stated that the existing reimbursement rate mechanisms would have increased rates to nursing facilities beyond what would fit within the 5% budget caps. The change to the reimbursement methodology is a four-year deal, and most nursing facilities can accept the change. The maximum annual rate increases provided in the proposed rule change are 7%, 7%, 3%, and 3% for the fiscal years 2008 through 2011. He added that the funds are appropriately partitioned in the budget.

Sec. Roob stated that the rate forecast is really only applicable to this biennium with any certainty since the QAF has not been extended for the entire four-year period covered by the rule change, CMS may not agree to continue the fee, and there is in fact a risk that something might happen to preclude extension of the QAF.

Mr. Scherer acknowledged that the proposed rule is much improved from the initial version. However, he added that the method of arriving at current nursing facility costs is a problem. The Case-Mix system is based on acuity level of the residents, but the

proposed rule does not compensate for change in acuity level. He stated that the IHCA is requesting that the new policy take into account the increases in the case-mix index. He added that not all facilities would be affected, but some would. Mr. Scherer acknowledged that the resulting cost impact could be greater than the $86 million projected for the Quality Assessment Fee, but he stated that the overage would be marginal in nature. Regarding where additional funds might come from, Mr. Scherer stated that the state could increase the QAF.

Mr. Jim Leich and Mr. Robert Decker testified in support of the proposed rule, but suggested continuing to work on the case-mix issue.

Nursing Facility Moratorium

In consideration of PD 3389, proposed by the administration, Mr. Sid Norton, FSSA, presented background information for the proposal. Mr. Norton reported the following: (1) In spite of demographic trends and the aging population, nursing facility utilization is decreasing in the general population and with the Medicaid program; (2) All but a very few states utilize some mechanism to exert direct control over nursing facility bed supply, while most states are increasing their investment in home- and community-based services, which decreases demand for nursing facility care; and (3) An emerging trend is utilization of risk-based managed care or enhanced primary care case management for the aged and disabled population, including those eligible for nursing facility care.

Mr. Norton described PD 3389 as (1) freezing the number of Medicaid-certified beds at the current level; (2) allowing for replacement and transfer of beds; (3) requiring any new beds to be offset by a corresponding reduction in beds; and (4) keeping the moratorium in place until 2011 or until the statewide occupancy rate reaches 95%.

Mr. Jim Leich, Indiana Association of Homes and Services for the Aging, stated that his organization was supportive of the approach reflected in the bill draft and supportive of the ability to buy and sell beds.

Mr. Mark Scherer, Indiana Health Care Association, stated that his association is neutral on the proposal, citing potential legal problems with the concept.

Mr. Bob Decker, Hoosier Owners and Providers for the Elderly, expressed support for the proposal, emphasizing that what the state wants to do is control supply of nursing facility beds while transitioning to home and community-based services, and the market will determine the value of a bed.

Mr. Randy Fearnow, Krieg DeVault, LLP, and representing American Senior Communities, stated that American Senior Communities is opposed to the proposal, believing that the moratorium on the construction or conversion of Medicaid-certified beds will stifle competition in the nursing home industry, impede the development of modern facilities, and would do little, if anything, to control Medicaid spending.

Provider Reimbursement

Dr. Jeff Wells updated the Commission on OMPP's plan to increase reimbursement to certain Medicaid providers, primarily physicians, transportation providers, and dentists. The plan includes two bonus payments along with a permanent fee increase. The first bonus payment to be made in state FY 2008 uses $10 million in state Medicaid funding carried over from FY 2007 and is prioritized for primary and preventative care services provided by family practitioners, general practitioners, obstetricians/gynecologists, general internists, and general pediatricians. Approximately 70% of the bonus payment ($18.7 million in state and federal funds) will be distributed through MCOs and 30% ($8 million in state and federal funds) through the fee-for-service system .

An estimated 3,800 managed care physicians will benefit with an average increase in payments of $4,929 and a median increase of $1,907. Payments are planned for December 2007.

An estimated 5,500 physicians in the fee-for-service system will benefit with an average increase in payments of $1,467 and a median increase of $723. Payments will be made as soon as possible after receiving approval for the Medicaid State Plan amendment from CMS.

Because many physicians provide services through both the managed care system and the fee-for-service system, OMPP estimates that approximately 7,000 different physicians will see an average bonus payment for FY 2007 of $5,000. However, the range of payment to physicians will vary significantly based on an individual physician's participation in the program.

A second bonus payment for the first half of FY 2008 will use approximately $4.6 million in state funds from the funding generated by HEA 1678-2007. A process similar to that described above will be used to distribute approximately $12.4 million in state and federal funds to physicians. Payments should be completed in the first quarter of CY 2008 for managed care physicians, with payments to fee-for-service physicians occurring by the end of FY 2008.

A permanent increase in physician reimbursement will use approximately $4.6 million in state appropriations from HEA 1678 and about $2.6 million from the Hospital Care for the Indigent (HCI) tax levy. This will result in additional managed care payments of $13.5 million and $5.8 million in fee-for-service payments (state and federal funds). These payments are expected to begin in January 2008.

In addition to the physician reimbursement increases, OMPP is planning a dental fee increase using $4.6 million in state funds to generate a total of $12.4 million in total additional funding. The state share will come from the funding generated by HEA 1678. These payments are expected to begin in January 2008.

OMPP also intends to use approximately $0.4 million in state funds from the HCI levy to

generate about $1 million in state and federal reimbursement for Medicaid transportation providers. These payments are expected to begin in January 2008.

Dr. Wells indicated that for the bonus payments, there will be an audit trail and a requirement imposed on the MCOs to pass the payments on to the physicians.

Mr. Randy Seals, representing the Indiana Ambulance Association, an association of municipally and privately owned ambulance services, asked the Commission for help regarding two issues: (1) equitable Medicaid compensation for ambulance and EMS services provided to Medicaid beneficiaries and (2) direct payment from health insurance organizations to ambulance service providers. Mr. Seals requested an increase in reimbursement rates as established by CMS and with reimbursement equal to the cost of providing the service. Currently, ambulance services are paid by the Medicaid program as transportation services with a base rate and mileage. Dr. Wells, stated that the ambulance providers would be included with the other Medicaid transportation providers in the forthcoming reimbursement rate increase.

Managed Care Organization Provider Access

Dr. Wells updated the Commission regarding access to MCO providers by distributing maps showing the location of health providers by region for MDwise, one of the state Medicaid MCOs. The three maps represented behavioral health providers, primary medical providers (PMPs), and specialists. Dr. Wells also provided information on the number of dentists and physicians by county participating in the Indiana Health Care Program. The data included the number of enrolled dentists, medical PMPs, and non-PMP physicians, as well as those actively billing the program, the percentage actively billing, and the members-to-provider ratios.

Mr. Roob stated that coverage is not as good in smaller, more rural counties as it is in larger, more urban counties.

Ms. Katherine Wentworth, MDwise, stated that MDwise produces geoaccess maps to ensure that the 30/60 mile requirements are met. (There must be a primary care provider within 30 miles and a specialist within 60 miles of recipients.) They also try to have multiple methods of outreach, including contacting patients who have accessed an emergency room, and MDwise looks for creative ways to pair up patients with the MCO's resources.

Regarding Medicaid reimbursement for transportation, Dr. Wells stated that there is typically reimbursement for 20 trips per year for medically necessary trips. Ms. Wentworth also stated that family members can also sign up as transportation providers.

Sec. Roob stated that access due to the number of physicians is probably weakest in West Central Indiana. Regarding how OMPP measures outcomes from the MCOs, Sec. Roob stated that the agency conducts monthly financial reviews and also receives

quarterly reports from the MCOs.

Managed Care Organization Behavioral Health

Dr. Wells informed the Commission that prior to January 2007, most behavioral health and substance abuse treatment for Indiana Medicaid and CHIP members was part of the traditional fee-for-service system, regardless of membership in an MCO. The state's goals in "carving in" behavioral health were to provide more holistic care, increase communication between the primary medical provider, MCO, and behavioral health providers, and to better manage utilization of behavioral health services.

Dr. Wells described the reasons for using managed care for behavioral health as the following: (1) to provide a medical home from which all types of needed care can be coordinated, provided, and managed; (2) to provide increased coordination between medical and behavioral health service providers; (3) to provide that MCOs and managed behavioral health organizations (MBHOs) accept financial risk to develop and manage networks and deliver covered services; (4) to increase member options and choice of services; and (5) to decrease care fragmentation.

Dr. Wells also discussed the following: (1) managed care tools; (2) access to care; (3) the medical management decision process; (4) prior authorization (PA) requirements; (5) behavioral health drugs; (6) managed care challenges; (7) common claims issues; (8) and a comparison of MCO behavioral health contracts data.

Ms. Cindy Peterson, Cenpatico Behavioral Health, the MBHO for Managed Health Services (MHS), stated that Cenpatico has been providing inpatient behavioral health services in Indiana since 2003. Their length of stay (LOS) for adults and children has averaged 4.7 days, while LOS for children has averaged 5.7 days. However, more importantly, their readmission rate has decreased to less than 10%. Ms. Peterson added that it is their goal to provide services in the least restrictive environment, so the inpatient LOS statistics are not always the most appropriate measure to use as an outcome measure. She added that there is significant variation in LOS between hospitals across the state.

Ms. Tina Berkeley, Magellan (MBHO for Anthem), indicated that over 95% of their claims are adjudicated within 10 days. Ms. Berkeley added that there are problems with billing technicalities, but that this is going better than what is sometimes heard. Regarding access to care, there is only one county in Indiana with less than 100% access, and they have received no complaints regarding access.

Mr. Steve Young, Magellan, cautioned the Commission that LOS data is only one piece of the total information; readmission rates were much more important. Mr. Young added that there are also reasons to be encouraged: (1) coordination of care is now occurring between the physical health system and the mental health system; (2) there is ambulatory followup on discharge plans; and (3) there is now more coordination between the providers and the MCOs.

Mr. Jim Jones, Indiana Council of Community Mental Health Centers (CMHCs), informed the Commission that there has, in fact, been a "rough rollout" to the managed behavioral health system, which has been even more challenging with Medicaid growth being held to 5%. Mr. Jones added that moving to a managed care process presents other challenges; one assumption was that the cost associated with contracting was estimated as 18% of the cost of services, and the 18% has to be made up by fewer services. This implies a $9 million reduction in services. The two cost containment tools permitted to MCOs is prior authorization and utilization, which leads to fewer people receiving services and less care provided to patients. Mr. Jones made three suggestions: (1) assure that the business plan model is not overly tipped to the profit side; (2) standardize protocols between MCOs, which is not the case now; and (3) have a greater integration of behavioral health with primary care. Mr. Jones stated that it is his hope that we can have a managed care program rather than a managed resource program.

Ms. Pat McGuffey, representing Indiana Psychological Association, informed the Commission that her association's experiences with the managed care organizations have been quite negative regarding the following: (1) denial of authorization for assessments and testing; (2) denial of authorization for treatment; (3) denial of authorization for the number of visits; and (4) the time and cost of administrative demands, such as the time spent on hold on the telephone and the increased amount of time spent on requirements that are not reimbursed.

Ms. Michelle Brochu, Comprehensive Behavioral Care (MBHO for MDwise), stated that the MCOs have been meeting behind the scenes to address the concerns expressed by the Commission and with the goal of providing good care and services in Indiana.

OMPP Contracting Issues

Ms. Judy Bunn, Executive Director of the Association of Indiana Home Medical Equipment and Service (AIHMES) Providers, a trade association with 86 member home medical equipment companies, expressed the concern that the association members were not informed of the impending changes in the recent request for proposal (RFP) project for incontinence, urological, and ostomy supplies until the last minute. According to Ms. Bunn, when AIHMES was made aware of a project focused on contracting with a single provider for these services, AIHMES immediately requested a meeting to discuss this proposal as well as other options. AIHMES was informed at a meeting with OMPP that a sole-source-provider project/contract was basically a "done deal" even though no RFP was issued, and no Indiana provider would be able to bid. The project was stopped, and a formal RFP was posted. However, AIHMES believes that the language in the RFP was to a significant extent written to eliminate all but a few select providers from successfully complying with the bid requirements. AIHMES also believes that a mail order program will actually lead to a reduction in quality of service.

Ms. Bunn made the following suggestions:

- The state should negotiate manufacturer rebates, similar to existing

pharmaceutical and hearing aid programs.

- The length of the contract in the RFP, stated as four years with two one-year renewals, seems to be excessive for an untried project; a two-year contract seems more appropriate, with an effective followup and study to be implemented at the end of the two years, before any additional contracts are awarded.

According to Ms. Bunn, AIHMES believes that recipients should have the freedom to choose their providers; wants all reputable providers to have realistic opportunities to provide Medicaid services; and as a responsible trade association, wants to work with the state on behalf of members and their patients to establish cost-effective, feasible provision of services to recipients and the state, while preserving the patient's freedom of choice.

Mr. Bill Lego from the Dr. Aziz Pharmacy stated that he was opposed to the RFP. Mr. Lego questioned why OMPP was requesting a four-year contract rather than a shorter-term trial. He was also concerned about his patients who were special needs children and require special-order products, but might be excluded from these products under this contract. Ultimately, he said, some kids may be sent to the hospital to get what they need, but at a higher cost to the state. Mr. Lego stated that he often delivers products to his patients' homes and questioned whether they would receive the same level of service from an out-of-state mail order company. He added that it was his understanding that under the RFP specifications, the only way to get a product changed was through a nurse's home visit. Mr. Lego also questioned why OMPP is willing to go out of state for a vendor, and he claimed that the state designed the RFP to effectively exclude small companies from competing for the contract. Mr. Lego also stated that a mail order company isn't always the most efficient in that often the company will send the maximum quantity of the product allowed under state rules rather than only the amount that the patient needs.

Ms. Kate McMullin, a grandmother of a 13-year-old who has undergone 37 major surgeries from spina bifida resulting in an augmented bladder, spoke of her granddaughter and her health problems and their experiences with Mr. Lego, their current product supplier. She stated that sending a nurse out to the home who doesn't know the child is not workable and added that her granddaughter requires a special soft catheter, which not only is not commonly stocked in drug stores, it is also not commonly stocked in hospitals; however, her supplier keeps them in stock for her. Ms. McMullin was concerned that she would not receive the same level of service from a mail order company.

Dr. Wells provided a slide presentation on the process for the contracting of incontinence supplies. He described the current system for Medicaid members and the anticipated impact on members from the new RFP. He outlined the time line for the RFP process, with an expected awarding of the contract in mid November. He also refuted what he believes are myths surrounding the RFP process.

Home and Community-Based Services in Indiana

Mr. John Cardwell, chairperson of the Indiana Home Care Task Force, described the preliminary results of three surveys conducted by the Home Care Task Force regarding issues affecting publicly funded home and community-based services (HCBS) in Indiana. The surveys cover three topics: (1) patterns of service usage in the CHOICE and Medicaid waiver programs, (2) general priorities in Indiana's HCBS system, and (3) the initial impact of welfare privatization on low-income seniors who use Medicaid-funded home and community-based services.

Mr. Cardwell's testimony included the following survey results:
The state needs to continue full funding of the CHOICE program.

- The state needs to spend CHOICE dollars on CHOICE services, despite the impact of SEA 493 and the 300% of SSI income-eligibility standard for Medicaid waivers.
- The Area Agencies on Aging (AAAs) need to be given more local decision-making authority and administrative power, which would streamline the system and make it more responsive to persons requiring home and community-based services.
- Surveyors found no one who believes that SEA 493 has been fully implemented, although there have been positive gains made.
- Welfare privatization represents a tangible threat to senior citizens and persons with disabilities who are disproportionately poor.
- The state currently has approximately 26,000 people in nursing homes, and this number would be under 13,000 if SEA 493 were properly implemented, CHOICE was fully utilized, and consumers were fully engaged and educated regarding long-term care.

Ms. Melissa Durr, Executive Director of the Indiana Association of Area Agencies on Aging, regarding pre-admission screening interviews in hospitals, stated that counselors not employed by a AAA are counseling patients in hospitals before the AAAs are notified and able to meet with the patient.

Ms. Linda Muckway, a CHOICE program client, described her experience on the CHOICE program and stated that being on CHOICE instead of Medicaid actually saves the state money because if she were on Medicaid, all of her medical costs would also be paid. She added that having to wait for services, often times for a minimum of six months, is counterproductive because in that amount of time, an individual's assets may be reduced to the point where the individual can no longer afford to live in the community rather than be on institutionalized Medicaid. She further stated that the concept of money following the person does not work in the long term.

EDS and MCO Updates

Mr. Sid Norton provided a comparison of the administrative cost per EDS claim paid. He reported that FSSA is considering in-sourcing or bidding the current EDS workload in different functional pieces rather than continuing to bid the contract in the same format as the current arrangement. The EDS contract has been extended by 6 months, until

December, 31, 2007, to allow FSSA time to determine the most appropriate mix of contracting functional pieces of the existing work and/or bringing some of the functions in-house to FSSA.

Dr. Wells reported on claims statistics for the three Medicaid managed care organizations (Anthem, MDwise, and MHS). The MCO reports generally included data on claims received, claims paid, claims denied, appeals, etc.

Mr. Tim Robl, EDS, provided an update on the Indiana Health Coverage Program (IHCP), which includes all of the IHCP programs and not just Medicaid. The report covered statistics through FY 2007. The report included statistics on dollars paid and numbers of claims, providers, and recipients for fiscal years 2005, 2006, and 2007. The report also contains statistics on IHCP spending by payment category for FY 2007, as well as operational statistics concerning claim volume by type, claim inventories, call center volume, and new provider enrollment data.

Care Select Program

Dr. Wells reviewed the goals of the Care Select program for pairing aged, blind, and disabled patients with primary care physicians. Dr. Wells also reviewed the progress of the bidding process for Care Select providers and informed the Commission that the Regenstrief Institute would be assisting FSSA in the review of proposals. He advised the Commission that the implementation of the program would begin with a phased rollout beginning with Central Indiana in October of 2007. Dr. Wells also stated that the provider reimbursement for planning and coordination services will be $15 per patient per month for Care Select patients.

Federal Changes Regarding Intergovernmental Transfers (IGTs)

Mr. Tim Kennedy, Indiana Hospital and Health Association, reviewed the new federal rule that will impact payments made to county and municipal hospitals, and to CMHCs in the state. The rule currently is not in effect, being subject to a one-year moratorium which is due to expire on May 29, 2008. The rule allows only entities that have taxing authority or that are an integral part of and controlled by an entity that has taxing authority to contribute funds for qualifying intergovernmental transfers. County hospitals and CMHCs in Indiana do not have taxing authority nor are the counties responsible for these entities. Since the CMHCs and county and municipal hospitals are the source of state matching funds for municipal upper payment limit payments, municipal disproportionate share hospital (DSH) payments, and rehabilitation option payments, these entities stand to lose many millions of dollars in additional Medicaid reimbursements that they currently receive. Mr. Kennedy testified that there is no other mechanism for another entity to contribute the state share of this funding. Wishard Hospital, under the auspices of the Health and Hospital Corporation, is not affected by this portion of the rule. However, Mr. Kennedy said that certain payments made to Wishard outside the DSH program currently, would be curtailed if the rule is

implemented. Mr. Kennedy commented that while other states are impacted by this rule, Indiana will be especially hurt.

Dr. Wells provided a document which showed that the federal Cost Limitations Rule clarifies that entities involved in the financing of the non-federal share of Medicaid payments must be a unit of government that has (1) taxing authority or (2) direct access to tax revenues as an "integral part" of a governmental unit that has taxing authority and is fully responsible for the health care provider's expenses, liabilities, and deficits. The document also showed non-general fund transfers into the state Medicaid program totaling $591.9 million. Of this amount, the intergovernmental transfers that are at risk because of the new rule total approximately $189.4 million.

CHIP Reauthorization

Sec. Roob updated the Commission on the federal reauthorization of the CHIP program. Sec. Roob stated that HEA 1678 from Indiana's 2007 legislative session increased eligibility under CHIP to 300% of the federal poverty level, which would result in a potential increase in federal expenditures in Indiana of $50 million. However, if the U.S. Senate bill which would increase federal cigarette taxes by $0.61 passes, Indiana citizens would pay an additional $300 million in cigarette taxes. Sec. Roob stated that Indiana should not be a donor state in health care. He added that state legislators should contact and lobby the state congressional delegation to vote against this bill and to provide more flexibility for the state to operate and conduct its own program.

Sec. Roob added that low-income states with high numbers of smokers tend to do poorly under this proposed bill. High-income states with low numbers of smokers tend to do well. He added that because the program expires September 30, 2007, the program will likely have at least a temporary reauthorization with discussions continuing for several months, and the likely timeline for federal action is August or September. Sec. Roob indicated that there were 16 states that would benefit from the Senate proposal and 29 states that would lose under the proposed federal bill.

Sec. Roob stated that some states would choose to cover children with incomes between 300% and 400% of the federal poverty level, but he doesn't believe health coverage for this particular population in Indiana is a problem. The Bush administration has made a recent change by proposing that a state must enroll at least 95% of Medicaid- and CHIP-eligible children to be allowed to provide coverage over 200% of the federal poverty level. Sec. Roob stated that in Indiana approximately 70% of CHIP-eligible children and about 60% of Medicaid-eligible children are enrolled.

HEDIS Reports

Dr. Wells discussed HEDIS measurements for the MCOs. The Healthcare Effectiveness Data and Information Set (HEDIS) reportedly is a widely used set of performance measures in the managed care industry, developed and maintained by the

National Committee for Quality Assurance (NCQA).

Medicaid Coordination of Benefits Study

Dr. Wells described SEA 566-2007 as requiring OMPP to examine Medicaid claims to determine and recover claims that were eligible for payment by third parties other than Medicaid. If the study determines that at least 1% of the claims were payable by a third party, OMPP is required to implement a procedure to improve the coordination of benefits between Medicaid and other third-party payers. Dr. Wells stated that the issue of third-party payers was highlighted in the federal Deficit Reduction Act of 2005. He added that approximately 11% to 12% of Medicaid recipients are estimated to have third-party payers other than Medicaid. Other states' data suggest that perhaps up to 20% may have third-party payers. Dr. Wells stated that EDS has subcontracted with HMS for cost recovery. He added that it is difficult to find and discover, but there are a lot of opportunities in this area.

V. COMMITTEE FINDINGS AND RECOMMENDATIONS

The Commission made the following recommendations.

Changes to a Medicaid Reimbursement Rule

After a proper motion and second, the Commission voted 9 to 0 in favor of a recommendation to adopt the proposed changes to 405 IAC 1-14.6-6 and 405 IAC 1-14.6-23, a rule for the reimbursement of nursing facilities.

PD 3333

PD 3333 repeals the provision that provides for the expiration of the Select Joint Commission on Medicaid Oversight on December 31, 2008.

The language of PD 3333 was further amended to add to the duties of the Select Joint Commission on Medicaid Oversight the determination of whether a managed care organization that has contracted with the state to provide Medicaid services has performed the terms of the contract. The amendment was adopted by consent.

Upon proper motion and second, the Commission voted 10 to 0 in favor of recommending PD 3333, as amended, to the General Assembly.

PD 3235

PD 3235 specifies that OMPP, a managed care organization that contracts with OMPP

under the state's Medicaid program, and a person that contracts with the managed care organization must meet certain requirements concerning payment and denial of claims.

Upon proper motion and second, the Commission voted 10 to 0 in favor of recommending PD 3235 to the General Assembly.

PD 3389

PD 3389 prohibits the State Department of Health from approving the certification of new or converted comprehensive care beds for participation in the Medicaid program until July 1, 2011, unless the state comprehensive care bed occupancy rate is more than 95% in health facilities. The bill allows for an exception for replacement beds if specified requirements are met.

The Commission adopted by consent a proposal to amend PD 3389 to exempt Continuing Care Retirement Communities from the requirements of the bill.

Upon final consideration, PD 3389 failed for lack of a motion.

Approval of Final Report

Upon proper motion and second, the final report of the Commission, with the inclusion of the testimony and actions of the October 29 meeting, was approved by a vote of 9 to 0.

W I T N E S S L I S T

Tina Berkeley, Magellan
Michelle Brochu, Comprehensive Behavioral Care
Judy Bunn, Executive Director, Association of IN Home Medical Equipment and Service Providers
Keenan Buoy, Myers and Stauffer
John Cardwell, Indiana Home Care Task Force
Bob Decker, Hoosier Owners and Providers for the Elderly
Melissa Durr, Executive Director, Indiana Association of Area Agencies for the Aging
Randy Fearnow, Krieg DeVault, LLP, representing American Senior Communities
Jim Jones, Indiana Council of Community Mental Health Centers
Lola Jordan, EDS
Tim Kennedy, Indiana Hospital and Health Association
Faith Laird, Indiana Health Care Association (IHCA)
Bill Lego, Dr. Aziz Pharmacy
Jim Leich, Indiana Association of Homes and Services for the Aging
Pat McGuffey, representing Indiana Psychological Association
Kate McMullin
Linda Muckway, CHOICE Program client
Sid Norton, Chief Financial Officer, FSSA
Cindy Peterson, Cenpatico Behavioral Health
Tim Robl, EDS
Mitch Roob, Secretary of FSSA
Mark Scherer, IHCA
Randy Seals, Indiana Ambulance Association
Steve Smith, Director of the Division of Aging
Jeffrey Wells, MD, Director, OMPP
Katherine Wentworth, MDwise
Steve Young, Magellan